

08092

## CERTIFICATE OF DEATH

08079

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 15 <b>15 YEARS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON, R.F.D. 5</b>		d. STREET ADDRESS <b>172</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>J.</b> Last <b>ANDERSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>FE MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/17/82</b>
9. AGE (In years last birthday) yrs. <b>84</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRESSMAKER</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN T. MOORE</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA SHAW</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-30-3961</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bil pulmonary embolism</b> DUE TO (b) <b>Thrombosis of right leg veins</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> , 19 <b>51</b> , to <b>6/1</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/1</b> 19 <b>67</b> , and that death occurred at <b>9 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Peter H. Rieckert</b>		22b. DATE SIGNED <b>6/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter H. Rieckert</b>		22d. ADDRESS <b>E.S.S.H., CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>June 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill North Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cherry Hill Cecil, Md.</b>
24. FUNERAL DIRECTOR <b>Ralph Hicks</b>		25a. REC'D BY REGISTRAR <b>Charles Jones</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>		DATE <b>JUN 5 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NOTED FOR

NOTED FOR

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> c. LENGTH OF STAY IN <u>5 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CAMBRIDGE-Md. Hosp.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>DORCHESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> d. STREET ADDRESS <u>806 CENTER</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ROSINA</u> Middle <u>BARKON</u> Last <u>BARKON</u> <b>4. DATE OF DEATH</b> Month <u>6</u> Day <u>3</u> Year <u>1967</u>						<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>NEGRO</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-28-1915</u> <b>9. AGE</b> (In years last birthday) <u>51</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>S. CAROLINA</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>						<b>13. FATHER'S NAME</b> <u>WASHINGTON MCKNIGHT</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH ROSE</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>MONROE SMITH</u> Address <u>806 CENTER</u>						<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia and Cardiac failure</u> <u>443X</u> DUE TO (b) <u>Hypertensive C.V.D.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>hypertensive C.V.D.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>[Signature]</u> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME</b> (Type) <u>[Signature]</u> <b>M.D. ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>6-6-67</u> Address (Street, city, town, or county)											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u> <b>22b. DATE THEREOF</b> <u>6/6/67</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>WAUGH CHAPEL</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>CAMBRIDGE MD</u>						<b>23. FUNERAL DIRECTOR</b> <u>Alma L. West</u> Address <u>Bellevue Md</u> <b>24a. REC'D BY REGISTRAR</b> <u>[Signature]</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> <b>DATE</b> <u>JUN 8 1967</u>					

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UNITED STATES DEPARTMENT OF AGRICULTURE

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FOR STATE  
HEALTH DEPT.

08094

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>O.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>18 MONTHS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>TILDEN</b> Last <b>BAXTER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/22/75</b>
9. AGE (In years last birthday) yrs. <b>91</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>RICHARD BAXTER</b>		14. MOTHER'S MAIDEN NAME <b>WILHEMENA CARMINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PNEUMONIA</b> DUE TO <b>FRACTURE NECK L. FEMUR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9047</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>5 MO.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <b>XX</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL IN HOSPITAL</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7</b> p.m. <b>L-2-67</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOSPITAL</b>	20f. (City or town) (County) (State) <b>CAMBRIDGE DOR. MD.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>6/27/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JUNE 30</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b>		23d. LOCATION (City or Town) (County) (State) <b>STEVENSVILLE MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 30 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08095					08082				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Dorchester			a. STATE		Maryland		
		MARYLAND			b. COUNTY		Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Cambridge			5 days		Rural-Cambridge				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?	
Cambridge Maryland Hospital					RFD # 3			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. AGE (In years last birthday)		
First LENA Middle THOMAS Last BENNETT					Month June Day 16 Year 67		73 yrs.		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				July 18, 1893		73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machine Operator				Shirt Factory		Dorchester Co., Maryland		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Levi Thomas					Anna Marshall				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			214-07-9796		Mr. Harry Bennett, RFD#3, Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated Duodenal ulcer &amp; peritonitis</u> DUE TO <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6/12/67</u> , 19 <u>67</u> , to <u>6/16/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/16/67</u> , 19 <u>67</u> , and that death occurred at <u>11:15</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Lawrence Maryanov</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>					22d. ADDRESS <u>610 Race St. Cambridge, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			June 19, 1967		Dail Family Cemetery		RFD #3, Cambridge, Md.		
24. FUNERAL DIRECTOR ADDRESS <u>LeCompte Funeral Service, Cambridge, Maryland</u>					25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

08034

Corvair Heart Disease  
Refracted Ocularly when Spectacles 3000

Lawrence W. Mays  
Lawrence W. Mays  
610 West 1st - Cambridge, MA  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

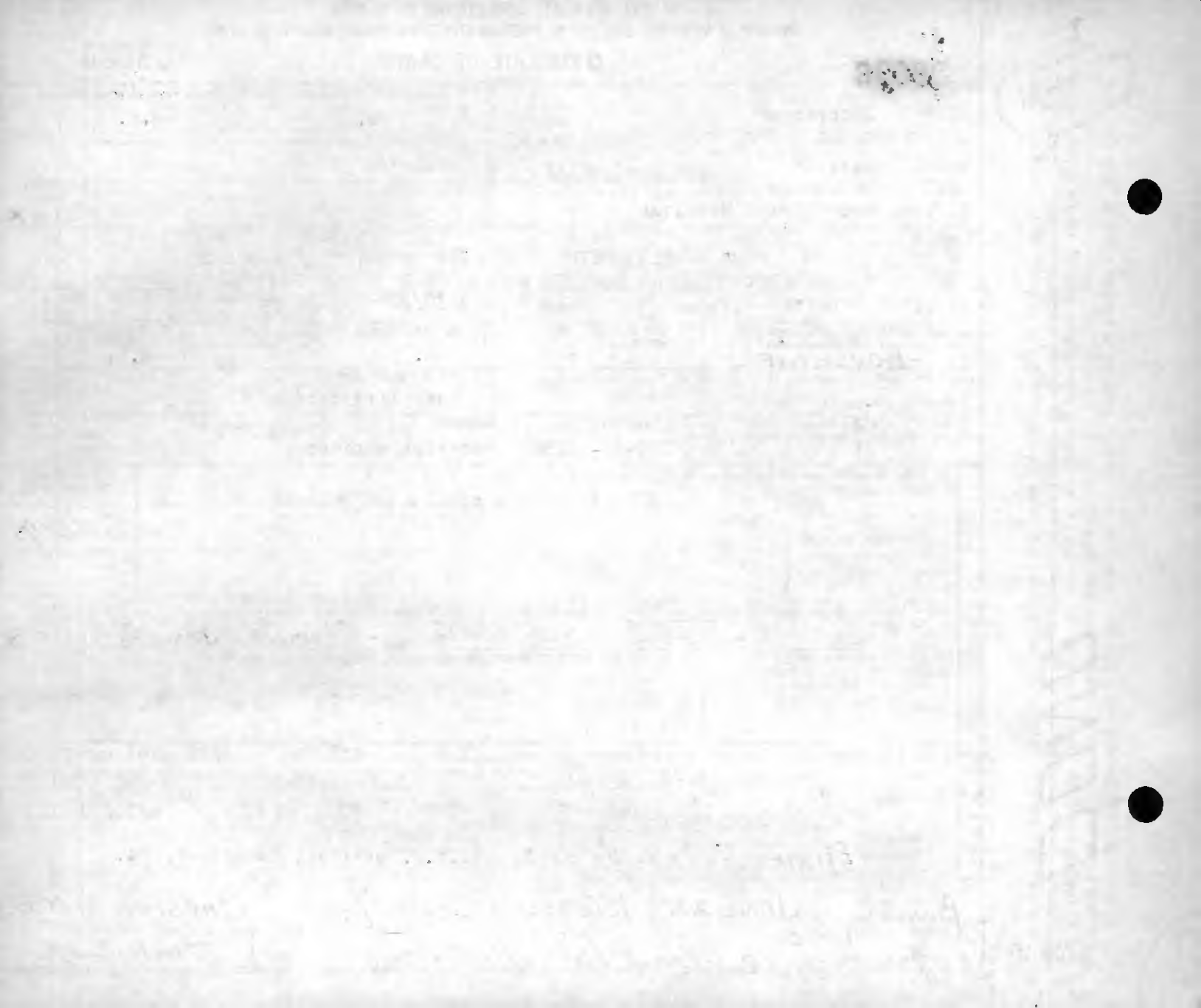
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>O.A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>			c. LENGTH OF STAY IN 1b <b>7 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHESTER</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ELIZABETH</b> Last <b>BENTON</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>1967</b>			
5. SEX <b>FE MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/30/92</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>XX</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JAMES H. BENTON</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH -</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-16-9923A</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. - Diabetes Mellitus - Chronic myocarditis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>67</b> , to <b>6/20</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/20</b> , 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Efrain C. Fernandez</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>6/20/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Efrain C. Fernandez</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JUNE 22</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KINGSLEY CHURCH YARD</b>		23d. LOCATION (City or Town) (County) (State) <b>CHESTER MD.</b>	
24. FUNERAL DIRECTOR <b>Edgar L. Lane Church Hill Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08097

CERTIFICATE OF DEATH

08084

1. PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY IN 16 <b>Life</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>BROWN</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1882</b>
9. AGE (In years last birthday) <b>85 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Ben Brown</b>		14. MOTHER'S MAIDEN NAME <b>Laura M. ( ? )</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Miss Mabel Wright, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of Esophageal Varices</b> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <b>Coronary Heart Disease with Cardiomegaly.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-2-56</b> , 19__, to <b>6-27-67</b> , 19__, that (I) (we) lost saw the deceased alive on <b>6-27-67</b> , 19__, and that death occurred at <b>1:15 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Albert E. Bunker</b> M.D.		22b. DATE SIGNED <b>6-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALBERT E. BUNKER, M. D.</b>		22d. ADDRESS <b>200 Md. Ave., Cambridge, Maryland 21613</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 29 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE MD</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glasgow Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>DORCHESTER</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE MD</b> d. STREET ADDRESS <b>312 GLENBURN LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>CAHALL</b>		4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-23-1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (in years last birthday) <b>74</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Cahall</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Chiffins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Louise Hughes Claymont, Delaware</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b> <b>YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>6-29, 1967</b> to <b>6-29, 1967</b> , that (1) (we) last saw the deceased alive on <b>6-29, 1967</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James F. McQuarrie</b>		22b. DATE SIGNED <b>6-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES F. MCQUARRIE</b>		22d. ADDRESS <b>Box 386 CAMBRIDGE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<b>Burial</b>	<b>7-2-67</b>	<b>Greensboro</b>	<b>Greensboro, Maryland</b>
24. FUNERAL DIRECTOR <b>J. E. Boreless &amp; Sons, Inc., Md</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b> 25b. REGISTRAR'S SIGNATURE	





08099

## CERTIFICATE OF DEATH

08087

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN lb <b>RURAL - CAMBRIDGE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>		d. STREET ADDRESS <b>CORDTOWN</b>	
3 NAME OF DECEASED (Type or print) <b>ROBERT HENRY CHESTER, JR</b>		4 DATE OF DEATH Month <b>JUNE</b> Day <b>6</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>FEB. 17, 1887</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO., MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT H. CHESTER, SR.</b>		14. MOTHER'S MAIDEN NAME <b>HARLETT ANNE JACKSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-07-9521 A</b>	
17. INFORMANT <b>FRANCES BROWN</b>		Address <b>CORDTOWN, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gangrene of left leg</b> 455 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 22</b> , 19 <b>67</b> , to <b>June 6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>June 6</b> , 19 <b>67</b> , and that death occurred at <b>---</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. FOLLEN FASSETT, M.D.</b>		22b. DATE SIGNED <b>June 10, 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. FOLLEN FASSETT, M.D.</b>		22d. ADDRESS <b>623 HIGH STREET CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CORDTOWN</b>	23d. LOCATION (City or Town) (County) (State) <b>CORDTOWN DORCHESTER MD.</b>
24. FUNERAL DIRECTOR <b>Judith C. Delaney</b>		25a. REG'D BY REGISTRAR DATE <b>14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08100

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03088

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Federalsburg - Rural</b>		c. LENGTH OF STAY IN b <b>10 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Finchville</b>			d. STREET ADDRESS <b>R.F.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILBUR</b> Middle <b>JENNINGS</b> Last <b>CHRISTOPHER</b>			4. DATE OF DEATH Month <b>June 18,</b> Day <b>19</b> Year <b>67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1898</b>	9. AGE (In years past birthday) <b>68</b> yrs	IF UNDER 1 YEAR Months <b>68</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Continental Can Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert J. Christopher</b>			14. MOTHER'S MAIDEN NAME <b>Ida M. Marshall</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-03-5904</b>		17. INFORMANT Address <b>Md. Mrs. Sarah A. Christopher, Federalsburg,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>am</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>			22. DATE SIGNED <b>6/20/67</b>		
EXAMINER'S NAME (Type) <b>John Mace Jr., M.D.</b>			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>		
23a. BURIAL/CREMATION OR REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>		23d. LOCATION (City or Town) (County) (State) <b>East New Market-Dorchester-Md</b>	
24. FUNERAL HOME <b>Frampton Funeral Home</b>		ADDRESS <b>Federalsburg, Md.</b>		25a. DATE <b>JUN 23 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with in 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08101

08090

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut an Residence before adm ssion) a. STATE <b>Md.</b> b. COUNTY <b>Queen Anne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Preston</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Rural Centreville</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Debra Cole man</b>		4 DATE OF DEATH Month Day Year <b>June 13 19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-13-1883</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <b>Queen Anne</b>		12 CIT ZEN OF WHAT COUNTRY? <b>Use</b>	
13. FATHER'S NAME <b>Ja mes Edward Cheers</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anthony</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>093-26-9944</b>	
17. INFORMANT <b>John Anthony</b>		Address <b>RFD Centreville</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardio Decompensation c auricular</b> <b>4211</b> DUE TO <b>Fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Chronic Congestiv Heart Failure control ed 5 yrs</b> DUE TO <b>Marked Aortic Ins fficiency</b> <b>15yrs</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND TION GIVEN IN PART I(a) <b>Cerebrovascular Accident (hemorrhage) 10days</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>1/8/57</b> , 19 <b>6/13/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6/12/67</b> 19__, and that death occurred at <b>12P</b> M, from causes and on the date stated above			
22a SIGNATURE <b>Dr. H. Dashiell-Easton</b>		22b DATE SIGNED <b>JUN 20 1967</b>	
22c PHYSICIAN'S NAME (Type) <b>Harold B. Blummer M.D.</b>		22d ADDRESS <b>P.O. Box #158 Preston Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>6-17-67</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Salem</b>		23d LOCATION (City or Town) (County) (State) <b>Centreville Queen Anne</b>	
24 FUNERAL DIRECTOR <b>H. H. Dashiell-Easton, Jr.</b>		25a REC'D BY REGISTRAR <b>JUN 20 1967</b>	
		25b REGISTRAR'S SIGNATURE <b>[Signature]</b>	





## CERTIFICATE OF DEATH

08102

08001

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MANOKIN</b>	
c. LENGTH OF STAY in lb <b>2 MO.</b>		d. STREET ADDRESS <b>Box 84, Route 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MOLLIE</b> Middle <b>C.</b> Last <b>FONTAINE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1869?</b>
9. AGE (In years last birthday) <b>98</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JAMES COTTMAN</b>	
14. MOTHER'S MAIDEN NAME <b>FANNIE -</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>213-16-7104A</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>Senile cachexia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> , 19 <b>67</b> to <b>6/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> , 19 <b>67</b> , and that death occurred at <b>1:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Carlos F. Barroso</b> M.D.		22b. DATE SIGNED <b>6/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REV. BUR</b>	23b. DATE THEREOF <b>6/25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN</b>	23d. LOCATION (City or town) (County) (State) <b>SOMERSET CO. MD.</b>
24. FUNERAL DIRECTOR <b>John C. [Signature]</b>		25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

100



08103

CERTIFICATE OF DEATH

08092

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Stevensville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Mary</u> Last <u>Fox</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-73</u>
9. AGE (in years last birthday) <u>93</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u> Hours <u>67</u> Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>F. W. Fox</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Watkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>216-05-01954</u>	
17. INFORMANT <u>Mrs LaRue Undergrove</u>		Address <u>Stevensville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left-Sided Pneumonia; Arteriosclerotic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>4</u> (this hospital) attended the deceased from <u>3-10-</u> , 19 <u>67</u> , to <u>6-9-</u> , 19 <u>67</u> , that <u>4</u> (we) last saw the deceased alive on <u>6-9-</u> , 19 <u>67</u> , and that death occurred at <u>9pm</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis, Jr.</u>		22b. DATE SIGNED <u>6-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR., MD</u>		22d. ADDRESS <u>Eastern Shore State Hosp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Witzke Funeral Director</u>		25a. RECEIVED BY REGISTRAR DATE <u>JUN 14 1967</u>	
ADDRESS <u>4401 Edmondson Ave</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

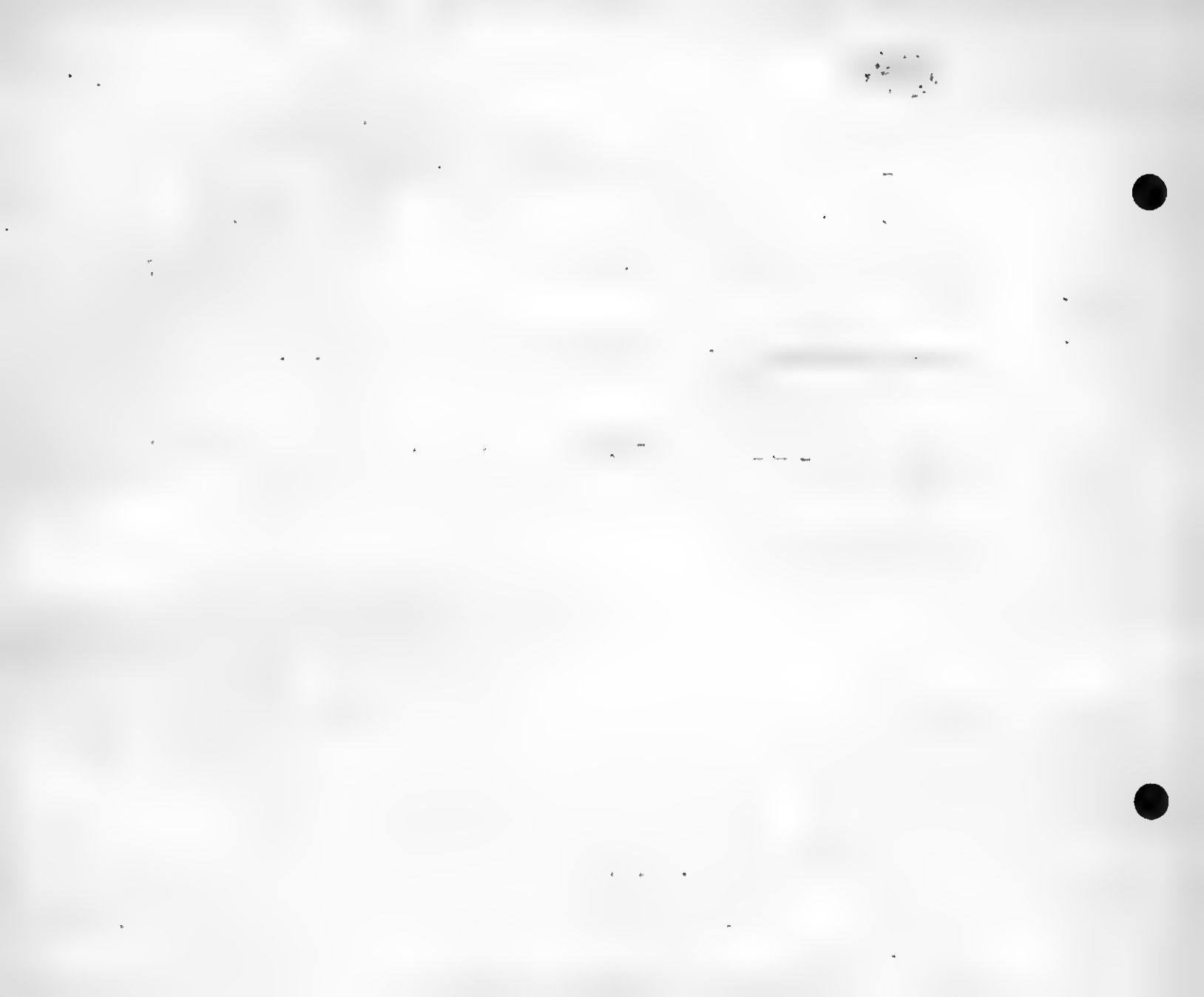
08093

08104

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Dist. Columbia</b> b. COUNTY <b>- - -</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c. LENGTH OF STAY IN 1b <b>One day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #3, Cooks Point Road</b>		e. STREET ADDRESS <b>114 Varnum Street, N.E.</b>	
3 NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>Wooding</b> Last <b>HINES</b>		4 DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 21, 1907</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Bakery Prod. Division</b>		11 BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Hines</b>	
14. MOTHER'S MAIDEN NAME <b>Grace Dampier</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>None -</b>	
16 SOC. A. SECURITY NO. <b>577-01-6921</b>		17 INFORMANT <b>Mrs. J. W. Hines, 114 Varnum St., N. E. Washington, D. C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>-</b> o.m. <b>-</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		22. DATE SIGNED <b>6/19/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>June 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co., Maryland</b>
24. FUNERAL DIRECTOR <b>Thomas Warner Pumphrey, 8434 Georgia Ave., Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 22 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





08105

## CERTIFICATE OF DEATH

08094

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Lucomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>306 Elizabeth St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hadley Francis Hobbs</u>		4. DATE OF DEATH Month Day Year <u>June 4 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>08-24-1907</u>
9. AGE 11 years (with day) yrs. <u>57</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>9 10</u>	IF UNDER 24 HRS Hours Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Shirt Factory</u>	11. BIRTHPLACE (County, state, or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Lafayette Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>SARA CAREY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-1833</u>	
17. INFORMANT <u>John F. Hobbs (son)</u>		18. ADDRESS <u>409 Newton Terrace, Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Hypertension - aging</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular accident</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 4</u> , 19 <u>67</u> , to <u>June 4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>June 4</u> , 19 <u>67</u> , and that death occurred at <u>1:40</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Milton O. Kepler</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>6-4-67</u>
22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>		22d. ADDRESS <u>East Shore State Hosp Cambridge MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Fruitland, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>111118</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



08106

## CERTIFICATE OF DEATH

08095

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>2 months today</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Bowers</u> Last <u>Hopkins</u>		4 DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/11/1884</u>
9 AGE (in years last birthday) <u>82</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>  </u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND - U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Clarence Hopkins</u>		14 MOTHER'S MAIDEN NAME <u>Anna Wilkens</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>		16 SOCIAL SECURITY NO <u>220-44-86575</u>	
17 INFORMANT Address <u>Eastern Shore State Hospital Medical Records</u>		18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile cachexia -</u>		(c) <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome with arteriosclerosis</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>		20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) <u>  </u>	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 29th, 1967</u> , to <u>JUNE 9th, 1967</u> , that (I) <u>we</u> last saw the deceased alive on <u>JUNE 9th, 1967</u> , and that death occurred at <u>7:45 A.M.</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Carlos F. Barroso</u> M.D.		22b. DATE SIGNED <u>6-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d. ADDRESS <u>Hurlock Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Family Burial Ground</u>	23d. LOCATION (City or Town) (County) (State) <u>Wye Mills, Md.</u>
24. FUNERAL DIRECTOR <u>Hermon E. Leonard, St. Michaels, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08107

# CERTIFICATE OF DEATH

08096

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Q.A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CENTREVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE 3</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>JACKSON</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NE GRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1886 ?</b>
9. AGE (In years last birthday) yrs. <b>81 ?</b>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>HOUSEWORK</b>	11. BIRTHPLACE (County & State, or foreign country) <b>QUEEN ANNE MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>-MARTINOWA</b>	
14. MOTHER'S MAIDEN NAME <b>HENNIE GASSAWAY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vasculor accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 27</b> , 19 <b>67</b> , to <b>JUNE 13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>JUNE 13</b> , 19 <b>67</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>E. C. Fernandez</i>		22b. DATE SIGNED <b>6/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. FERNANDEZ</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>6-16-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EARL CHAPEL</b>	23d. LOCATION (City or Town) (County) (State) <b>RED. CENTREVILLE, MD.</b>
24. FUNERAL DIRECTOR <i>Charles Judge</i>		25. REC'D BY REGISTRAR <b>JUN 19 1967</b>	
26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		27. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08097

1 PLACE OF DEATH a COUNTY <u>Dorchester</u> MARYLAND x		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE (RURAL) approx 5 days</u>		c LENGTH OF STAY IN 1b <u>MARYLAND (RURAL)</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN Shore State Hospital</u>		d. STREET ADDRESS <u>R.F.D. #1 Box 155</u>	
3 NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4 DATE OF DEATH Month <u>6-29</u> Day <u>19</u> Year <u>67</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>00-00-82?</u> 9 AGE (In years lost birthday) <u>85?</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not listed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Wesley Johnson</u>		14 MOTHER'S MAIDEN NAME <u>Lou Cindy Johnson</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO <u>Not listed</u>	
17 INFORMANT <u>Eastern Shore State Hospital (Medical Record)</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant Nephrosclerosis</u> DUE TO (b) <u>Diabetes mellitus</u> DUE TO (c) <u>20 years-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>6-21</u> , 19 <u>65</u> , to <u>6-29</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>6-29</u> 19 <u>67</u> , and that death occurred at <u>4</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Carlos F. Barros</u>		22b. DATE SIGNED <u>6-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>		22d ADDRESS <u>Hurlock Md-</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>7/1/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>HADAWAY CHAPEL</u>	23d LOCATION (City or Town) (County) (State) <u>Chesapeake Kent Md</u>
24 FUNERAL DIRECTOR <u>Fennell</u>		25a REC'D BY REGISTRAR <u>JUL 6 1967</u> 25b REGISTERED <u>John Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1  
2

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08103  
CERTIFICATE OF DEATH  
03093

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>Rural</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Reba</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 7, 1893</b>	9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Church Creek</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Frank E. Vickers</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>Howard C. Jones</b>		17. INFORMANT <b>Howard C. Jones, Church Creek, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>5 YRS</b> <b>UNDER</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/1, 1966</b> to <b>6/9, 1966</b> , that (I) (we) last saw the deceased alive on <b>6/9, 1966</b> , and that death occurred <b>6:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Alfred R. Maryanov</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>6/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>				22d. ADDRESS <b>610 RACE ST, CAMBRIDGE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity Churchyard</b>		23d. LOCATION (City, town or county) (State) <b>Church Creek, Md.</b>	
24. FUNERAL DIRECTOR <b>Howard C. Jones</b>				25. PREPARED BY REGISTRAR <b>14 1967</b>			
ADDRESS <b>Cambridge, Md.</b>				DATE <b>14 1967</b>			
				REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08099

FOR STATE  
HEALTH DEPT

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY In lbs <b>15 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>612 Chesapeake Court</b>		d. STREET ADDRESS <b>612 Chesapeake Ct.</b>	
3. NAME OF DECEASED (Type or print) <b>Willie Lawrence</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1920</b>
9. AGE (In years last birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>45</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Susie Douglas, Cambridge, Md.</b>	
17. INFORMANT <b>Susie Douglas, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>4541</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>6/8/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) <b>Cambridge, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Cambridge, Dor., Md.</b>
24. FUNERAL DIRECTOR <b>St. Clair Funeral Co.</b>		25. REC'D BY REGISTRAR <b>14 1967</b>	
ADDRESS <b>Cambridge, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11 12 13 14 15



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08111

CERTIFICATE OF DEATH

08100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>			c. LENGTH OF STAY IN TB <u>50 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>RFD 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Elizabeth</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1897</u>		9. AGE (In years last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Moaney</u>				14. MOTHER'S MAIDEN NAME <u>Julia Bolden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-2747A</u>		17. INFORMANT <u>Hester Stanley, RFD 2, Cambridge, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1967</u> to <u>June 13, 1967</u> , that (I) (we) lost saw the deceased alive on <u>June 13, 1967</u> and that death occurred at <u>  </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 15, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. EDWIN FASSETT, MD</u>				22d. ADDRESS <u>623 HIGH STR ET CAMBRIDGE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/13/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cordtown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Dorchester County, Md.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u> ADDRESS <u>Cambridge, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08112

08101

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, forwarding the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY in 1b <b>about 60 yrs</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>120 Mill Street</b>				d STREET ADDRESS <b>120 Mill Street</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT H. MATTHEWS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 27, 1884</b>		9. AGE (in years last birthday) <b>82</b> yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor-Ins. Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate- Ins.</b>		11. BIRTHPLACE (State or foreign country) <b>Fairmount, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Sewell Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Esther Dobson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>unk</b>		17. INFORMANT Address <b>Donald E. Matthews, Cambridge, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO HALL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Mace Jr.</b>		EXAMINER'S NAME (Type) <b>John Mace Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>6/20/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 21, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no event, within 72 hours after death.

VR A15 (4)  
20 M 1/64

081113

CERTIFICATE OF DEATH

29529

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMPIDGE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- CAMBRIDGE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>		d. STREET ADDRESS <b>AIREYS, MD.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>SOPHIE</b> Middle <b>T.</b> Last <b>MILLER</b>		4 DATE OF DEATH Month <b>JUNE</b> Day <b>29</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>OCT. 8, 1871</b>
9a. AGE (In years last birthday) <b>92</b> yrs		9b. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	9c. IF UNDER 24 HRS Hours <b>0</b> M. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>	11. BIRTHPLACE (County & State or foreign country) <b>DORCHESTER CO., MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JAMES H. THOMAS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY NASH</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>216-56-1786</b>		17. INFORMANT <b>BELLE BUTTNGHUS</b> Address <b>AIREYS, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac dec ompensation</b> DUE TO <b>arteriosclerotic C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 29, 1967</b> to <b>June 29, 1967</b> (that (I) (we) last saw the deceased alive on <b>June 29, 1967</b> ), and that death occurred at <b>19</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. EDWARD FASSETT, M.D.</b>		22b. DATE SIGNED <b>JUNE 30, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. EDWARD FASSETT, M.D.</b>		22d. ADDRESS <b>623 HIGH STREET CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SALEM</b>	23d. LOCATION (City or Town) (County) (State) <b>SALEM DORCHESTER MD.</b>
24. FUNERAL DIRECTOR <b>Frederick C. Delius</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>		25c. ADDRESS <b>CAMPIDGE, MD.</b>	

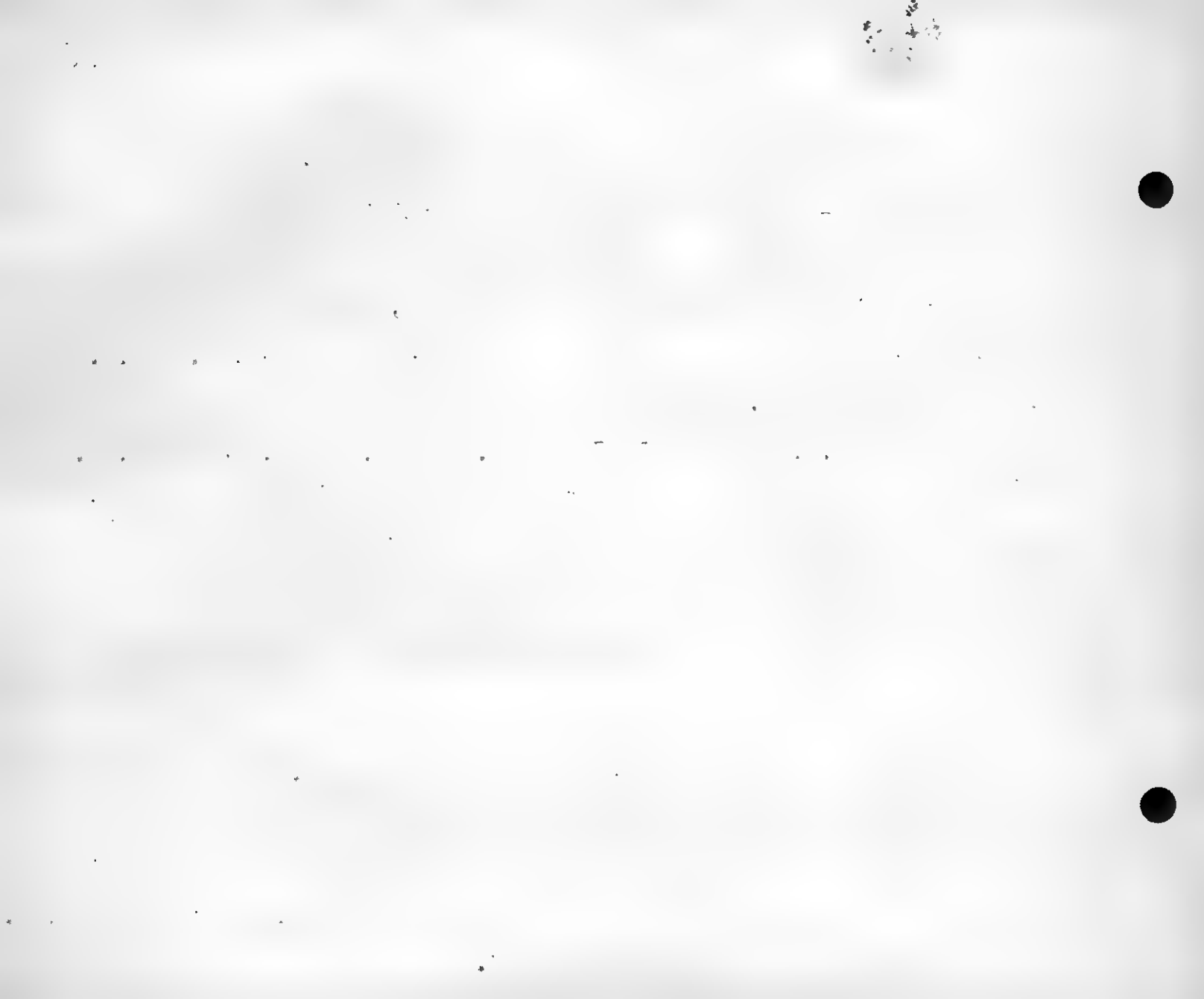


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08114 CERTIFICATE OF DEATH 08102

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>6 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		e. STREET ADDRESS <b>417 Edlon Park</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marion Dewey Mohler</b>		4. DATE OF DEATH Month Day Year <b>June 8, 1967 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1898</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Mardella Springs, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles L. Mohler</b>		14. MOTHER'S MAIDEN NAME <b>Irene Hopkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 214-07-7587</b>	
17. INFORMANT <b>Mrs. Elsie H. Mohler, Cambridge, Md.</b>		Address <b>417 Edlon Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Carcinoma of Prostate gland</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>20 yrs</b> <b>1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13/45</b> to <b>6/9/67</b> , that (I) (we) last saw the deceased alive on <b>6/9/67</b> , and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence Maryanov</b>		22b. DATE SIGNED <b>6/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>		22d. ADDRESS <b>600 Race St. Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>East New Market, Md.</b>	
24. FUNERAL DIRECTOR <b>James D. Thomas</b>		25a. RECEIVED BY REGISTRAR <b>June 14 1967</b>	
ADDRESS <b>Cambridge, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08115

08103

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Der</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		- 7.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Clyde</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/1904</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millworker - Adkins Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Moore</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lap Keord</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs John Clyde Moore, Hurlock, Md</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia, Congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-15</u> , 19 <u>67</u> , to <u>June 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> , 19 <u>67</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Carlos F Barroso</u>				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u>				22d. ADDRESS <u>Hurlock Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		23d. LOCATION (City, town or county) (State) <u>Hurlock Md</u>	
24. FUNERAL DIRECTOR <u>Kath S. Willoughby, East New Market, Md</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	





88116

CERTIFICATE OF DEATH

08104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Williamsburg</u>		c LENGTH OF STAY IN 1b <u>Two Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Marys Rest Home</u>		d STREET ADDRESS <u>Rural - Williamsburg</u>	
3 NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Opher</u> Last <u>Opher</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1895</u>
9 AGE (In years last birthday) <u>72</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Dorchester County, Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Stanley</u>	
14. MOTHER'S MAIDEN NAME <u>Virginia Trehern</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>212-74-4084</u>		17. INFORMANT <u>Nellie Jones, Baltimore, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction near the Colostomy</u> 538 DUE TO <u>Colostomy from Carcinoma of the Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease Mentally Incompetent</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/30/66</u> , 19 <u>66</u> to <u>6/7.67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>6/7</u> 19 <u>67</u> , and that death occurred on <u>6:30 A</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Harold B. Plummer</u>		22b. DATE SIGNED <u>6/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>		22d. ADDRESS <u>P.O. Box #158 Preston Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/14/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waucho Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>
24 FUNERAL DIRECTOR <u>Herbert M. A. Claug</u>		25a REC'D BY REGISTRAR DATE <u>JUN 16 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

2021



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08117 CERTIFICATE OF DEATH 08105									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>30 Years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>205 Crusader Road</b>					d. STREET ADDRESS <b>205 Crusader Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Byrn</b> Last <b>Phelps</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1967</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>March 8, 1892</b>		9. AGE (In years last birthday) <b>75</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance salesman, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Md., R.D. 2</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Francis P. Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Byrn</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>	
17. INFORMANT <b>Mrs. Eva L. Phelps, Cambridge, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis (V.D.)</b> DUE TO (c) <b>Arteriosclerosis gen</b>		INTERVAL BETWEEN ONSET AND DEATH <b>59 1/2</b> <b>minutes</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1946</b> to <b>6/20/67</b> , that (I) (we) last saw the deceased alive on <b>6/20</b> <b>1967</b> , and that death occurred at <b>12:15</b> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>James G. Thompson</b>		22b. DATE SIGNED <b>6/21/67</b>		22c. PHYSICIAN'S NAME (Type) <b>James G. Thompson</b>		22d. ADDRESS <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park, Cambridge, Md.</b>		23d. LOCATION (city, town or county) (State) <b>Cambridge, Md.</b>			
24. FUNERAL DIRECTOR <b>James R. Thomas</b>		25a. REC'D BY REGISTRAR <b>JUN 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



08118

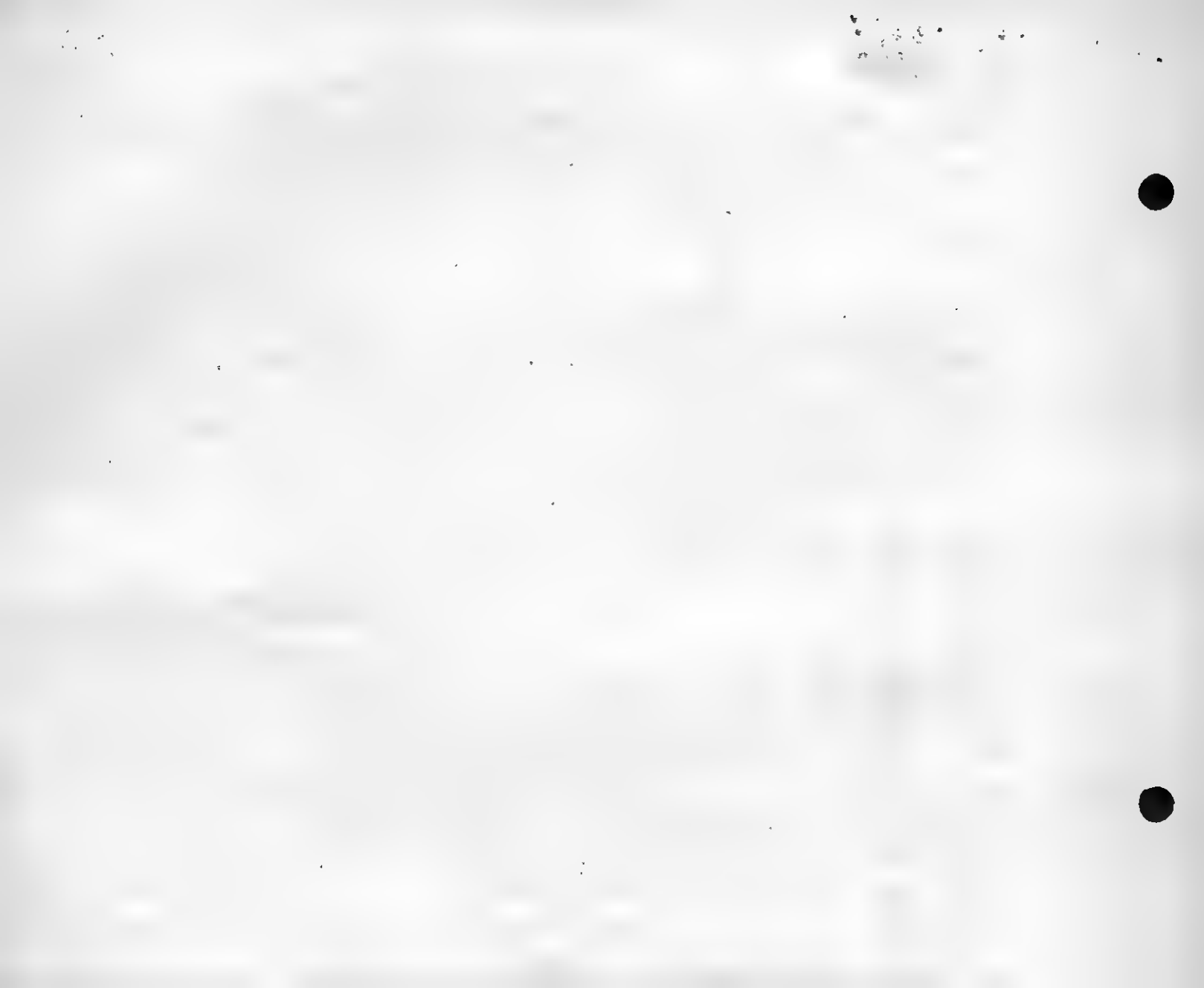
## CERTIFICATE OF DEATH

08106

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>WICOMICO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DELMAR</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>Pine Street</b>	
3 NAME OF DECEASED (Type or print) First <b>ROGER</b> Middle <b>Williams</b> Last <b>PUSEY</b>		4 DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/10/05</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing Co.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Md. Wicomico Co.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>REVERDY PUSEY</b>	
14. MOTHER'S NAME <b>ELIZABETH DORA WILLIAMS</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT <b>Albert Pusey (Brother)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>H3N1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/17</b> , 19 <b>38</b> , to <b>6/16</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> , 19 <b>67</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>6/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EFRAIN C. FERNANDEZ</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>June 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Delmar, Delaware</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>JUN 20 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

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08119

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08107

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Queen Anne's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>715 GLENDALE AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>Rufus</b> Middle <b>Edmund</b> Last <b>Radcliffe</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>CAUCASION</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 21, 1884</b>
9. AGE (In years last birthday) <b>82</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>STEVENSVILLE D.A. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Alfred Radcliffe</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE ELMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-01-3735</b>	
17. INFORMANT <b>wife</b> Address <b>Mrs. Ebbal L. Radcliffe, Centreville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4531</b> DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> (b) <b>AND BUEGGER'S DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>? 2 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POSS. PULMONARY ABSCESS; URINARY BLEEDING</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>we</b> (this hospital) attended the deceased from <b>6-21-</b> 19 <b>67</b> to <b>6-24-</b> 19 <b>67</b> , that <b>we</b> (we) last saw the deceased alive on <b>6-24-</b> 19 <b>67</b> , and that death occurred at <b>9:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward Lewis Jr. M.D.</b>		22b. DATE SIGNED <b>6-24-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD LEWIS JR. MD</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSP.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 22, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery, Centreville, D.A. Co. Md.</b>		23d. LOCATION (City or town) (County) (State) <b>Centreville, D.A. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>James H. Baiter, Barton Bros., Centreville, Md.</b>		25a. RECD BY REGISTRAR <b>June 27, 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08120		08108	
1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>1 year 11 months 18 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover (Rural)</u>		d. STREET ADDRESS <u>Eastern Shore State Hospital</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ONA</u> Middle <u>MAY</u> Last <u>Reid</u>		4 DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>01-09-87</u>
9 AGE (In years last birthday) <u>80</u> yrs		10 IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>19</u> Min <u>67</u>	
10a US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Taylor</u>		14 MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO <u>Med. Care #3248</u>	
17 INFORMANT <u>Eastern Shore State Hospital (Medical Records)</u>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>chronic brain generalized debilitation</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>chronic brain syndrome</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (if this hospital) attended the deceased from <u>5-20-1966</u> , to <u>6-28-1967</u> , that (if) (we) last saw the deceased alive on <u>6-28-1967</u> , and that death occurred at <u>6:25 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>Arthur Blair Webster</u>		22b DATE SIGNED <u>6-28-67</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/1/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Beechwood</u>		23d LOCATION (City or Town) (County) (State) <u>Princess Anne Somerset Md</u>	
24 FUNERAL DIRECTOR <u>Steven H. Harris</u>		25a REC'D BY REG. STAFF <u>30 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	



## CERTIFICATE OF DEATH

19525

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>		d. STREET ADDRESS <b>818 ROBBINS STREET</b>	
3 NAME OF DECEASED (Type or print) <b>CHARLES EDWARD ROBINSON</b>		4 DATE OF DEATH Month <b>JUNE</b> Day <b>21</b> Year <b>1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1893</b>
9 AGE (In years last birthday) yrs <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11 BIRTHPLACE (Country & State or foreign country) <b>DORCHESTER CO., MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>JOHN ROBINSON</b>		14 MOTHER'S MAIDEN NAME <b>MARY ELIZABETH CLASH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>220-09-1898 A</b>	
17. INFORMANT <b>MARY AGNES ROBINSON</b>		Address <b>CAMBRIDGE, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO <b>Hypertensive Arteriosclerotic C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>---</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1967</b> , to <b>June 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 21, 1967</b> , and that death occurred at <b>---</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. J. Edwin Fassett, M.D.</b>		22b. DATE SIGNED <b>June 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>P.O. 576 62, High Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL</b>	23d. LOCATION (City or town) (County) (State) <b>CAMBRIDGE DOR. MD.</b>
24 FUNERAL DIRECTOR <b>Julius C. DeLois</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 11 1967</b>	
ADDRESS <b>CAMBRIDGE, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Julius C. DeLois</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08122

CERTIFICATE OF DEATH

08109

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb <b>entire life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>900 Maryland Ave.,</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>900 Maryland Ave.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mitchell</b> Middle <b>Shorter</b> Last <b>Shorter</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1967</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1, 1897</b>		9. AGE (in years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Hospital Attendant, Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sewards, Dorchester Co., U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Jesse Shorter</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Willey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>900 Maryland Ave</b>		17. INFORMANT <b>Mrs. Ida May Shorter, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric haemorrhage</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>nephritis, chronic</b> (c) <b>Anemia, old hemiplegia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia, old hemiplegia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>?</b> <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June 29, 1967</b> to <b>June 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 29, 1967</b> and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>7/1/67</b>				22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>	
22d. ADDRESS <b>[Signature]</b>				22e. ADDRESS <b>[Signature]</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR <b>James R. Thomas</b>				25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



38123

## CERTIFICATE OF DEATH

08110

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>4 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		d. STREET ADDRESS <b>R. F. D.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>DELLA</b> Last <b>SINGLETARY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 19, 1903</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Stanley</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>220-16-9357</b>	
17. INFORMANT <b>Ide Singletary, Rhodesdale, Md., RFD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bilateral pulmonary embolism</b> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>embolism</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. W. Rieckert</b>		22b. DATE SIGNED <b>6-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. W. Rieckert</b>		22d. ADDRESS <b>East New Market</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rhodesdale Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Rhodesdale, Maryland</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p><b>08124</b></p> <p><b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> </div> <div> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b></p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>08111</b></p> </div> </div>													
<b>1. PLACE OF DEATH</b> a. CDUNTY <b>Dorchester</b> <span style="float: right;">MARYLAND</span>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Dorchester</b></span>								
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			<b>c. LENGTH OF STAY IN 1b</b> <b>4 weeks</b>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Madison</b>								
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					<b>d. STREET ADDRESS</b> <b>Route 16 Rural</b>			<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Myrtle</b> Middle Last <b>Snook</b>					<b>4. DATE OF DEATH</b> Month <b>June</b> Day <b>14</b> Year <b>1967</b>		<b>5. SEX</b> <b>Female</b>						
<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan. 1, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>81</b> yrs. <table border="1" style="display: inline-table;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
Hours	Min.												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Rutherford, Ontario</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>						
<b>13. FATHER'S NAME</b> <b>Lyman W. Snook</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah E. Oliver</b>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>220-48-2414</b>		<b>17. INFORMANT</b> Address <b>Frederick S. Snook, Madison, Md.</b>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>DIABETES MELLITUS</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>IMMEDIATE</b>				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)						
<b>21. I certify that (1) (this hospital) attended the deceased from <u>5-17</u>, 19<u>67</u>, to <u>6-14</u>, 19<u>67</u>, that (2) (we) last saw the deceased alive on <u>6-14</u>, 19<u>67</u>, and that death occurred <u>2 A.M.</u> from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <i>James F. McCarter</i>					<b>22b. DATE SIGNED</b> <b>6-14-67</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JAMES F. MCCARTER</b>						
<b>22d. ADDRESS</b> <b>Box 386 Cambridge, Maryland 21613</b>					<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>23b. DATE THEREOF</b> <b>June 16, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Joppa Churchyard</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Madison, Md.</b>						
<b>24. FUNERAL DIRECTOR</b> <i>Herbert L. Thomas Jr.</i>					<b>25a. REC'D BY REGISTRAR</b> <b>JUNE 27 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>						

MEDICAL CERTIFICATION



08125

CERTIFICATE OF DEATH

08112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>DERCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) <u>Daisie ATKINS</u> First Middle Last		4. DATE OF DEATH <u>June 4, 1967</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>U</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-80</u>
9a. AGE (In years last birthday) <u>86</u> yrs.		9. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia - USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE ATKINS</u>		14. MOTHER'S MAIDEN NAME <u>Slusher ELIZABETH ATKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>219 56 8075</u>	
17. INFORMANT <u>EASTERN SHORE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary artery occlusion</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0 -</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>03-22, 1967</u> to <u>06-04, 1967</u> , that (I) (we) last saw the deceased alive on <u>06-04, 1967</u> , and that death occurred at <u>9:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Milton O. Kepler</u> M.D.		22b. DATE SIGNED <u>6-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>		22d. ADDRESS <u>Eastern Shore State Hosp Cambridge MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>near Kennedyville, Md.</u>
24. FUNERAL DIRECTOR <u>Willis Wells</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>Chestertown, Md</u>		DATE <u>JUN 6 1967</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08126

08113

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		c LENGTH OF STAY IN 1b <b>8 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		e STREET ADDRESS <b>None</b>	
3 NAME OF DECEASED (Type or print) First <b>PERCY</b> Middle <b>TODD</b> Last		4 DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 3, 1884</b>
9 AGE (In years last birthday) <b>83 yrs</b>		F UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>	
11 BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Noah L. Todd</b>		14 MOTHER'S MAIDEN NAME <b>Fannie Insley</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>218-05-1670</b>	
17 INFORMANT <b>Mrs. Leonard Bramble, Bishops Head, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>6/8/67</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>June 10, 1967</b>	23c NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24 FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a REC'D BY REGISTRAR <b>JUN 14 1967</b> DATE	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08127

CERTIFICATE OF DEATH

C8114

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admiss on) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN It <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>303 Maryland Avenue</b>		d. STREET ADDRESS <b>303 Maryland Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>BRAMBLE</b> Last <b>TRAVERS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1896</b>
9. AGE (In years last birthday) <b>70</b> yrs		IF UNDER 1 YEAR Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>T. Milbourne Bramble</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>unk</b>	
17. INFORMANT <b>Mr. Herbert Travers, Cambridge, Maryland</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>157X</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MED. CAL. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-23-62</b> , 19__, to <b>6-16-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>6-11-67</b> , 19__, and that death occurred at <b>4 A.M.</b> from causes and on the date stated above.			
22a SIGNATURE <i>Albert E. Bunker</i>		22b. DATE SIGNED <b>6-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>		22d. ADDRESS <b>200 Md. Ave., Cambridge, Md. 21613</b>	
23a BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24 FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>26 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



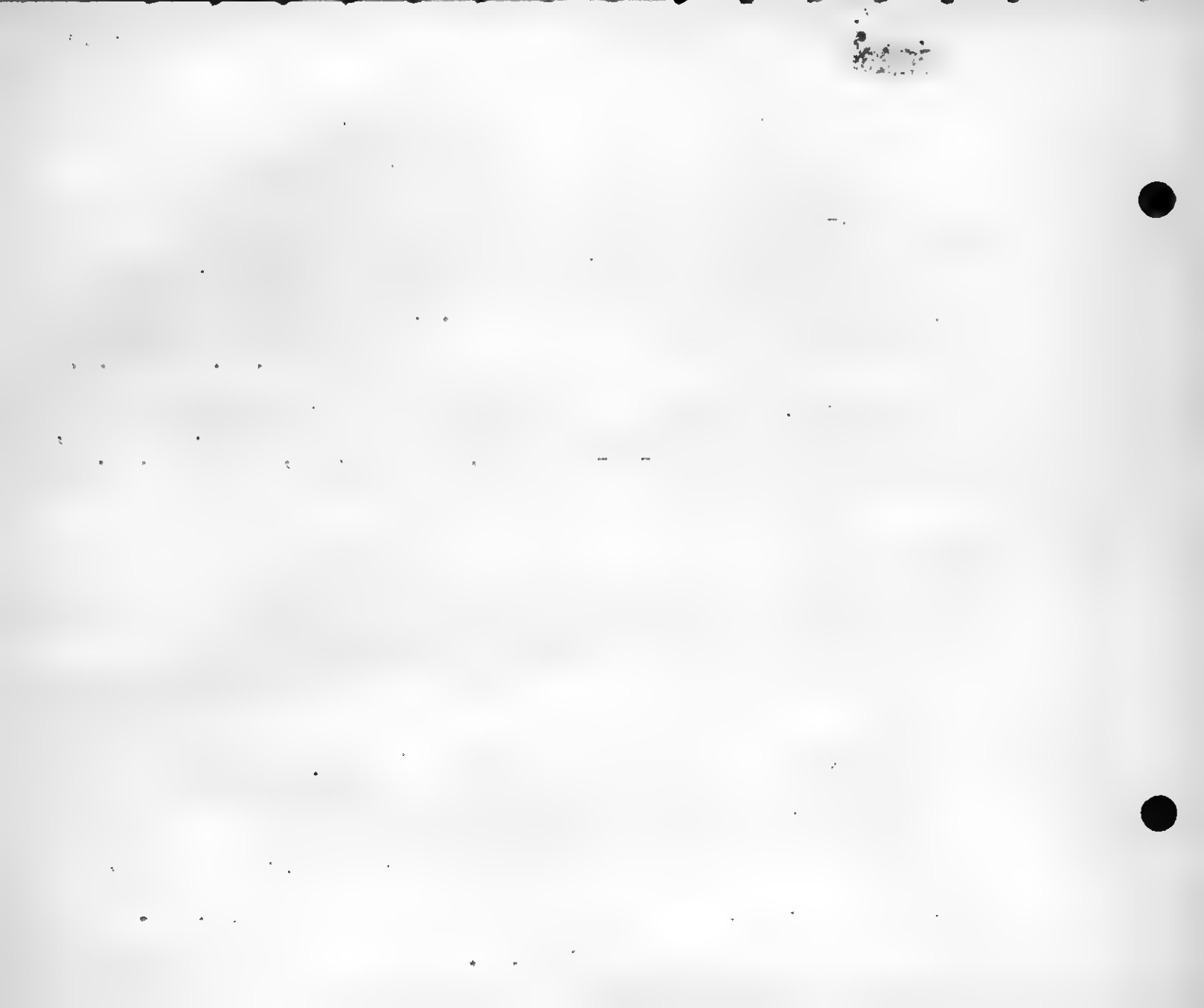


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
08128 CERTIFICATE OF DEATH 08115										
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>5 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS <b>716 Race Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Randolph</b> Last <b>Trigger</b>					4. DATE OF DEATH <b>June 1, 1967</b> Month <b>June</b> Day <b>1</b> Year <b>19</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 3, 1922</b>		9. AGE (in years last birthday) <b>45 yrs.</b> IF UNDER 1 YEAR: Months <b>45</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Fredericksburg, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James H. Trigger</b>					14. MOTHER'S MAIDEN NAME <b>Amanda Shackelford</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>252-09-4273</b>		17. INFORMANT <b>Mrs. Amanda North, Cambridge, Md.</b> Address <b>906 Camelia St.,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <b>5-24-67</b> 19 to <b>6-1-67</b> 19, that (we) last saw the deceased alive on <b>6-1-67</b> 19, and that death occurred at <b>4:34 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>James F. McCarter</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>6-2-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>JAMES F. McCARTER, M.D.</b>					22d. ADDRESS <b>Box 386 Cambridge, Md. 21613</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 3, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Cambridge, Md.</b>			
24. FUNERAL DIRECTOR <b>Samuel D. Thomas</b>					ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John L. Jones</b>	



08129

## CERTIFICATE OF DEATH

08116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Lucan Honey</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMMINGTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>Box 112</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Huckett</u> Last <u>Kinsant</u>				4. DATE OF DEATH Month <u>06</u> Day <u>04</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>01-06-74</u>	
9. AGE (in years last birthday) <u>9.3</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John N. Kinsant</u>				14. MOTHER'S MAIDEN NAME <u>Emily C. Cooke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>215-14-5395</u>		17. INFORMANT <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> stating the underlying cause last (c) <u>aging - senescence</u>							
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia and Coarctation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>05-27</u> , 19 <u>67</u> , to <u>06-04</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>06-04</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Milton O. Kepler</u>				22b. DATES SIGNED <u>6-4-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MILTON O. KEPLER</u>				22d. ADDRESS <u>CUMMINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Galena Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Galena Kent Md.</u>	
24. FUNERAL DIRECTOR <u>Edward Holloway</u>				25a. REC'D BY REGISTRAR <u>William J. Judge</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08130

08117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Glasgow Nursing Home</i>		d. STREET ADDRESS <i>rural Trappe</i>	
3. NAME OF DECEASED (Type or print) <i>DASSY V. WATTS</i>		4. DATE OF DEATH Month <i>June</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 2, 1883</i>
9. AGE (In years last birthday) <i>83 yrs</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>William Sand</i>		14. MOTHER'S MAIDEN NAME <i>Emma Frazier</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO <i>213-16-7399</i>	
17. INFORMANT <i>Mrs. James S. Chaplain</i>		Address <i>13 Willis St. Easton, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO (b) <i>generalized Arteriosclerosis</i> DUE TO (c) <i>10 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/23/67</i> to <i>6/24/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/24/67</i> , and that death occurred at <i>6:15</i> M., from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence Maryanov</i>		22b. DATE SIGNED <i>6/27/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. Lawrence Maryanov</i>		22d. ADDRESS <i>Cambridge, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	23b. DATE THEREOF <i>6-27-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Landing Neck</i>	23d. LOCATION (City or town) (County) (State) <i>rural Trappe Talbot Md.</i>
24. FUNERAL DIRECTOR <i>Maureen E. Newman-John</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 29 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

8131

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9546

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>?</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hurlock</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spencer Jones Labor Camp</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter</b> First <b>Whitney</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>36</b> yrs		10. UNDER 1 YEAR Months <b>?</b> Days <b>?</b>	11. UNDER 24 HRS Hours <b>?</b> Min <b>?</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer, migrant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO <b>?</b>	
17. INFORMANT <b>Deputy Sheriff Hurley. Cambridge</b>		Address <b>Dor. Cp. Jail</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO (b) <b>Shot gun wound chest</b> DUE TO (c) <b>?</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Shot by Sarah Abney</b>	
20c. TIME OF INJURY Month, Day, Year <b>12 N. 6/27/67</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> not at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <b>Labor Camp Near Hurlock, Dor., Md.</b>		20f. (City or town) (County) (State) <b>Cambridge, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>6/28/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		23b. DATE THEREOF <b>6/28/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Balto. City Morgue</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Herbert M. Anderson</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08132

## CERTIFICATE OF DEATH

08118

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>				d. STREET ADDRESS <u>705 Church St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Hicks</u> Last <u>Willis</u>				4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/30/1900</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	IF UNDER 24 HRS. Hours <u>6</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Hampton B. Hicks</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Reed</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Paul Willis, Wilmington, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis bifurcation of abdominal aorta</u> DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/31/67</u> to <u>6/2/67</u> , that (I) (we) last saw the deceased alive on <u>6/2</u> 19 <u>67</u> , and that death occurred at <u>3:20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Lawrence Maryanov</u>				22b. DATE SIGNED <u>6/3/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>	
22d. ADDRESS <u>610 Race St. Cambridge, Md</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>6/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town or county) (State) <u>East New Market, Md</u>	
24. FUNERAL DIRECTOR <u>Arthur S. Halloway, East New Market</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. The first part of the paper is devoted to a general discussion of the problem of the existence of solutions of the system of equations

which are satisfied by the functions  $u_i$  and  $v_i$  in the domain  $G$  of the plane. The second part of the paper is devoted to a detailed study of the problem of the existence of solutions of the system of equations

08133

CERTIFICATE OF DEATH

08119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HELEN S. WINSLOW</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>74</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Hearn</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Peters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Mr. David Winslow, Vienna, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA FROM</b> 1532 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF DESCENDING COLON</b> DUE TO (c) <b>8 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 25, 1966</b> , to <b>JUNE 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>JUNE 26, 1967</b> , and that death occurred at <b>7:30 A.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Alfred R. Maryanov</b>		22b. DATE SIGNED <b>6/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Alfred R. Maryanov, M.D.</b>		22d. ADDRESS <b>610 Race St., Cambridge, Md. 21613</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>June 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 3 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
6M 1/66

08134

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08120

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		d. STREET ADDRESS <b>416 GOLDSBORO STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LEONARD FAIRBANKS WYATT</b>		4. DATE OF DEATH Month Day Year <b>JUNE 18 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>01-06-12</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOSPITAL ATTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES WYATT</b>		14. MOTHER'S MAIDEN NAME <b>ALICE KEMP</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>213-05-6233</b>	
17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Pending/autopsy/report</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary occlusion</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>6/19/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>6/22/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>	
24. FUNERAL DIRECTOR <b>MAURICE E. NEUNAM &amp; SON, Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 26 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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